Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: CHANNELVIEW MEDICAL CENTER 3033 FANNIN STREET HOUSTON, TX 77004	MFDR Tracking #:	M4-09-8538-01
Respondent Name and Box #: HOUSTON ISD REP. BOX #: 21		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "We are requesting your assistance in processing the medical bills related to the above-mentioned patient for DOS 05/21/2008. The carrier has failed to respond to these bills within 45 days of receipt of the bills as required by TWCC Rule 133.204(a) AND has failed to respond within 21 days after faxing a 2nd attempt to collect payment. Due to the said reasoning, we are requiring your intervention to collect payment according to the fee schedule for the services provided."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $141.61
3. CMS 1500s
4. Medical Record

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…Requestor is seeking reimbursement for date of service May 21, 2008 in the amount of $141.61. Provider states that a response was never received in this matter from Respondent. Houston ISD received the bill at issue on June 17, 2008. The bill was sent back to the provider on July 21, 2007 and was denied due to lack of documentation. The provider did not request reconsideration until this request for Medical Dispute Resolution. As such, the provider has not followed the correct procedure prior to requesting MDR. The Respondent's position is that its denial was appropriate. For the above-referenced reasons, it is the position of the Respondent that no additional reimbursement is due for date of service May 21, 2008. The billed charges were properly paid, reduced or denied in accordance with the Medical Fee Guidelines. Additional reimbursement is not due based on the documentation submitted for this medical dispute…"

Principle Documentation:

1. Response to DWC 60
2. EOB dated 07/21/2008

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount Ordered
05/21/08	CPT Code 99214 (53.68 ÷ 36.0666) x $93.22 = $138.74 The Requestor is seeking $126.61)	1, 2, 4, 5	$126.61
05/21/08	CPT Code 99080	1, 3	$ 15.00
Total:			$141.61

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and 28 Texas Administrative Code (TAC) Sections 134.203, titled *Medical Fee Guideline for Professional Services* and 134.204, titled *Medical Fee Guidelines for Workers' Compensation Specific Services* on or after March 1, 2008, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "16 (X358) – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Documentation was not submitted or was insufficient to review charge" and "172 (Z121) – Payment is adjusted when performed/billed by a provider of this specialty. Level II certified provider." Neither party submitted an EOB for CPT Code 99080-73.
2. The Respondent states in their position summary that the Requestor did not request reconsideration. However, the Requestor included a fax confirmation sheet for the request for reconsideration, submitted to Crawford Insurance on April 24, 2009 in accordance with Division rule at 28 TAC Section 133.250. The Requestor submitted the office visit record to support the service was rendered as billed. Therefore, in accordance with Division rule at 28 TAC Section 134.203, reimbursement for CPT Code 99214 is recommended.
3. The EOB submitted by the Respondent did not address CPT Code 99080-73 and neither party has submitted an EOB addressing the Work Status Report. The Requestor submitted Form DWC-73 to support the service was rendered as billed. Therefore, in accordance with Division rule at 28 TAC Section 129.5(i) reimbursement in the amount of $15.00 is recommended.
4. Per review of Box 32 on CMS-1500, zip code 77015 is located in Harris County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.
5. In accordance with Division rule at 28 TAC Section 133.307(c)(2)(C) the requestor is seeking reimbursement in the amount of $126.61, which is less than MAR. Therefore, payment is recommended in the amount of $126.61.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sections 413.011(a-d), 413.031, and 413.0311
28 Texas Administrative Code Section. 134.1, 134.203, 134.204, 133.250
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $141.61 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution	August 6, 2009 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.